

REQUEST FOR ADMINISTRATIVE HEARING FOR RECORD CORRECTION

Administrative Hearing Submission

In re: ‘Iolani Pu‘u Kolenc (f/k/a Misa Kelly)

Case No. 19CR09754

CII A38857042

Prepared Pro Se

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SECTION I — OPENING STATEMENT

The record in this case reflects that charges were filed and later dismissed through a mental health diversion process.

The evidence reflects a different sequence.

On October 12, 2019, a medical emergency occurred.

A urinary tract infection produced acute delirium.

At the time charges were filed on October 15, 2019, I was documented as unable to participate in shared decision-making.

On October 16, the court authorized involuntary medication under a Riese order, requiring a finding that I lacked capacity to make medical decisions.

The infection was identified after admission.

Antibiotic treatment was initiated.

The symptoms resolved.

The treating psychiatrist before the event documented stable outpatient functioning.

The current treating psychiatrist documents PTSD/C-PTSD and trauma-related symptoms, not chronic psychotic illness.

The record reflects a criminal and psychiatric framework.

The evidence reflects a medical event during a period of incapacity.

This submission requests correction of the record so that it accurately reflects the documented medical nature of the October 2019 event.

The current charges, which list felony charges, and charges dismissed, under a mental health diversion program do not align with factual evidence.

All I am seeking, is for the record to align with the facts.

Thank you.

‘Iolani Pu’u Kolenc

SECTION II — EXECUTIVE SUMMARY

Issue Presented

The current DOJ and diversion-related record reflects:

- criminal conduct,
- psychiatric causation,
- and a mental health diversion resolution.

The evidence reviewed since obtaining the underlying records reflects a materially different chronology.

The documentary record shows:

- a medical emergency,

- acute delirium associated with urinary tract infection,
- documented incapacity,
- involuntary treatment proceedings,
- delayed medical diagnosis,
- and clinical improvement following antibiotic treatment.

The submission does not seek to relitigate the original criminal matter.

The request is for administrative record correction based upon:

- the actual sequence of events,
- the medical evidence,
- the documented incapacity,
- and significant discrepancies within the later diagnostic framework.

Core Position

The evidence supports the conclusion that the October 2019 event was primarily medical in nature rather than evidence of chronic psychotic criminal behavior.

The central issue is not whether a crisis occurred.

The central issue is whether the official record accurately reflects:

- the medical nature of the event,
- the documented incapacity,
- the sequence of treatment,
- and the legal significance of consciousness and intent.

SECTION III — GOVERNING LEGAL FRAMEWORK

Governing Standard

Under California Penal Code §26:

A person who acts without consciousness cannot commit a crime.

A criminal act requires:

1. a voluntary act
2. the capacity to form intent

Unconsciousness and Delirium

A person may appear active while lacking awareness of actions or surroundings.

Conditions associated with incapacity and altered consciousness may include:

- delirium,
- acute medical disorientation,
- impaired awareness,
- inability to participate meaningfully,
- and loss of memory regarding events.

Apparent activity alone does not establish conscious intent.

Incapacity and Riese Proceedings

A Riese hearing authorizes involuntary medication when a patient lacks the capacity to consent to treatment.

The records in this case document:

- inability to participate in shared decision-making,
- refusal/inability to meaningfully engage in treatment planning,
- and involuntary medication proceedings.

The same cognitive functions required for informed medical consent are also central to:

- understanding actions,
- forming intent,
- and voluntary conduct.

Due Process Requirements

Due process requires:

- reliable evidence,
- fair procedures,
- opportunity to participate,
- and decisions grounded in verified facts.

Where incapacity exists, proceedings must account for that limitation.

Exculpatory Medical Evidence

Medical evidence relating to consciousness, delirium, mental state, or causation is materially relevant to criminal intent and due process review.

Record Accuracy

State records should accurately reflect:

- the nature of the event,
- the medical evidence,
- and the actual basis of legal findings.

Where the record materially conflicts with the evidence, correction is appropriate.

SECTION IV — CORE ARGUMENT: INCAPACITY AND CONSCIOUSNESS

What the Record Currently Reflects

The current record structure reflects:

- criminal charges,
- mental health diversion,
- psychiatric causation,
- and dismissal through diversion.

This framework implies that psychiatric illness caused criminal conduct.

What the Evidence Reflects

The evidence reflects a materially different sequence.

The records document:

- acute delirium associated with urinary tract infection,
- inability to participate in decision-making,
- disorientation and altered awareness,
- involuntary medication proceedings,
- delayed identification of the infection,
- and improvement following antibiotic treatment.

Capacity and Intent

The Riese proceedings established lack of capacity to consent to treatment.

The same cognitive capacity is required to:

- understand actions,
- form intent,
- and engage in voluntary conduct.

The evidence raises substantial questions regarding the existence of conscious voluntary intent during the relevant period.

Clinical Consistency Across Time

Before the Event

Treating records document:

- outpatient level care,
- stable functioning,
- no chronic psychotic deterioration,
- and normal functioning shortly before October 2019.

During the Event

The records document:

- acute disorientation,
- inability to participate,
- delirium,
- involuntary treatment,
- and delayed identification of UTI.

After Treatment

The records document:

- improved orientation,
- return of coherent communication,
- and stabilization after antibiotic treatment.

Current Clinical Status

Current treatment records reflect:

- PTSD/C-PTSD,
 - trauma-related symptoms,
 - dissociation history,
 - and review of possible prior misdiagnosis.
-

SECTION V — CHRONOLOGICAL SEQUENCE OF EVENTS

October 1, 2019

Documented outpatient stability.

October 12, 2019

- 911 call regarding behavioral crisis
- Law enforcement response
- Jail custody rather than hospital medical evaluation
- No documented medical clearance

October 15, 2019

Admission to PHF.

Records document:

- inability to participate,
- refusal/declined answers,
- impaired capacity,
- and no urinalysis ordered at intake.

Criminal complaint filed while still in custody.

October 16, 2019

- Riese order initiated
- involuntary medication authorized
- antipsychotic medications administered

October 17–18, 2019

- urinary tract infection identified
- antibiotic treatment initiated

October 18–22, 2019

Clinical improvement documented:

- improved orientation,
- coherent communication,
- increased participation,

- stabilization.

October 22, 2019

Dr. Griffith documents delirium and identifies the UTI as the ultimate cause of the presentation.

2020

Mental health diversion order entered.

2025–2026

Current psychiatrist documents PTSD/C-PTSD framework and reviews possible prior misdiagnosis.

SECTION VI — MEDICAL TREATMENT TIMELINE

Admission Findings

At intake:

- no urinalysis (UA) was ordered,
- a lipid panel was ordered,
- and the patient was documented as unable to participate.

Capacity Documentation

The Patient Engagement Tool documents:

- “Declined to answer”
- signature marked “Refused”
- notation: “Unable to participate in shared decision making due to severity of symptoms.”

Medication Sequence

Antipsychotic medications were initiated before the urinary tract infection was identified.

The medication records document administration of:

- Zyprexa (olanzapine)
- Haldol (haloperidol)
- Ativan (lorazepam)

- Cogentin (benztropine)
- Seroquel (quetiapine)

Medical Diagnosis

The urinary tract infection was identified after admission and after psychiatric medications had already been initiated.

Antibiotic treatment was then ordered.

Clinical Improvement

The records subsequently document:

- improved orientation,
- coherent speech,
- increased participation,
- and stabilization.

Significance of Sequence

The chronology reflects:

No diagnostic testing at intake →
 Incapacity documented →
 Antipsychotic medications initiated →
 UTI identified later →
 Antibiotics initiated →
 Symptoms improve.

SECTION VII — DUE PROCESS AND SEQUENCE FAILURE

Required Sequence

A medically impaired individual should ordinarily receive:

1. medical evaluation,
2. capacity assessment,
3. treatment of underlying medical causes,
4. competency and intent review,
5. then charging decisions if appropriate.

Actual Sequence Reflected in the Records

The records reflect:

1. emergency response,
2. incarceration,
3. criminal complaint,
4. involuntary psychiatric medication,
5. delayed medical diagnosis,
6. later antibiotic treatment,
7. subsequent recovery.

Core Due Process Concern

The central concern is whether the criminal and psychiatric framework was established before the underlying medical cause was identified and evaluated.

One-Sided Evidentiary Structure

The records also reflect substantial reliance upon:

- third-party statements,
- reporting-party narratives,
- and documentation created while the patient was incapacitated.

The submission requests review of whether the resulting record accurately reflects the totality of the evidence.

SECTION VIII — DIAGNOSTIC AND RECORD DISCREPANCIES

Longitudinal Diagnostic History

The longitudinal treatment history reflects:

- trauma-focused treatment,
- PTSD/C-PTSD,
- dissociative symptoms,
- and limited hospitalization history.

1997 Plesons Consultation Note

The original 1997 consultation documented:

- Dissociative Disorder with secondary depressive features,
- intact orientation and memory,
- no psychosis,
- and no homicidal or suicidal ideation.

Later Emerick Characterization

The later diversion-related evaluation attributed:

- schizoaffective disorder,
- medication history,
- and longitudinal psychiatric framing

that materially differs from the content of the original 1997 consultation.

Medication History

The medication history reflected in the records does not appear consistent with sustained high-dose antipsychotic treatment commonly associated with chronic psychotic illness.

The documented outpatient Seroquel dosage prior to hospitalization was 25 mg.

Current Clinical Context

Current treating psychiatrist Dr. Scott Dewhirst documents:

- PTSD/C-PTSD,
- trauma-related symptoms,
- dissociation/depersonalization,
- and review of possible prior diagnostic misinterpretation.

SECTION IX — CURRENT CLINICAL CONTEXT

The present request is based not only on retrospective review, but on the emergence of records and medical analysis unavailable during the original proceedings.

The review of records obtained after the diversion proceedings reflects:

- substantial diagnostic inconsistency,
- evidence of acute delirium,

- documented incapacity,
- and a materially different medical framework than the one reflected in the current record.

The delay in bringing this request was not due to neglect.

The request follows:

- later access to records,
 - forensic review,
 - medical reevaluation,
 - and the ability to understand the significance of the documentary sequence.
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SECTION X — REQUEST FOR RECORD CORRECTION

This submission respectfully requests review and correction of the record to reflect:

- the documented medical nature of the October 2019 event,
- the evidence of delirium and incapacity,
- the delayed identification of urinary tract infection,
- the actual sequence of treatment,
- and the substantial discrepancies within the psychiatric framing later incorporated into the record.

This request does not seek to relitigate the underlying criminal matter.

The request seeks administrative correction so that the official record more accurately reflects:

- the medical evidence,
 - the chronology,
 - the documented incapacity,
 - and the actual clinical context.
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SECTION XI — EXHIBIT INDEX

Foundational Exhibits

Exhibit A — Baseline Clinical Status

Exhibit B — Onset Timeline

Exhibit C — Medical Treatment Timeline

Exhibit D — Incapacity Documentation
Exhibit E — Griffith Letter
Exhibit F — Medication Records
Exhibit G — Sequence Failure Analysis
Exhibit H — Forensic Record Discrepancy Analysis
Exhibit I — Current Clinical Context (Dewhirst)
Exhibit J — One-Sided Record Structure
Exhibit K — Equitable Tolling Timeline

Visual Demonstratives

- Due Process Sequence Failure
- Due Process Breakdown
- PHF Due Process Timeline
- Medication Timing Timeline
- Court Filing Timeline
- Equitable Tolling Timeline

Supporting Records

- PHF Admission Orders
- Physician Orders
- Medication Logs
- Patient Engagement Tool
- Riese Documentation
- Dr. Griffith Letter
- Dr. Bolton Records
- Dr. Dewhirst Letter
- Diversion Order
- Plesons Consultation Note
- Emerick Evaluation Comparison

SECTION XII — EXHIBITS

EXHIBIT A — BASELINE CLINICAL STATUS

Purpose

Documents stable outpatient functioning and clinical baseline prior to the October 2019 event.

Core Findings

- Outpatient level of care prior to October 2019
- No documented acute psychosis immediately before the event
- Stable functioning documented by treating providers
- Longitudinal history reflects trauma-focused treatment rather than chronic deterioration

Supporting Documents

- Dr. Bolton records
- Pre-event clinical notes
- 2019 activity and functioning records
- Academic and professional records

Key Significance

The abrupt onset of severe confusion and incapacity is medically more consistent with acute delirium than progressive chronic psychotic deterioration.

EXHIBIT B — ONSET AND EMERGENCY RESPONSE TIMELINE

Purpose

Documents the initial emergency response and the transition from medical crisis to criminal processing.

Chronology

October 12, 2019

- 911 call reporting behavioral crisis
- Law enforcement response
- Crisis described as psychiatric/medical emergency

- Jail custody initiated
- No documented hospital medical clearance prior to jail

October 12–15, 2019

- Continued custody
- No documented urinalysis
- No documented medical rule-out process

October 15, 2019

- Admission to PHF
- Criminal complaint filed while still in custody
- Capacity impairment documented

Core Finding

The records reflect that criminal processing proceeded before the underlying medical condition was identified.

EXHIBIT C — MEDICAL TREATMENT TIMELINE

Purpose

Documents the sequence of evaluation, medication, diagnosis, and recovery.

October 15, 2019 — PHF Admission

- No urinalysis (UA) ordered
- Lipid panel ordered
- Patient documented as unable to participate

Capacity Documentation

Patient Engagement Tool documents:

- “Declined to answer”
- Signature marked “Refused”
- “Unable to participate in shared decision making due to severity of symptoms.”

October 16, 2019

- Riese proceedings initiated
- Involuntary medication authorized
- Antipsychotic medications administered

October 17–18, 2019

- Urinary tract infection identified
- Antibiotic treatment initiated

October 18–22, 2019

Clinical improvement documented:

- increased orientation
- coherent speech
- improved participation
- stabilization

Sequence Summary

No diagnostic testing at intake →
Incapacity documented →
Antipsychotic medications initiated →
UTI identified →
Antibiotic treatment initiated →
Symptoms improve.

Supporting Documents

- PHF admission orders
- Medication logs
- Physician orders
- Patient Engagement Tool
- Nursing and treatment records

EXHIBIT D — INCAPACITY DOCUMENTATION

Purpose

Documents inability to participate in decision-making and formal incapacity findings.

Documentary Evidence

Patient Engagement Tool

Documents:

- refusal/inability to answer questions

- inability to engage in treatment planning
- inability to participate in shared decision-making

Riese Proceedings

The Riese proceedings authorized involuntary medication based upon lack of capacity.

Clinical Notes

Records document:

- confusion
- disorientation
- inability to participate
- altered awareness

Core Finding

The records contemporaneously document incapacity during the same period in which criminal charges were pursued.

EXHIBIT E — DR. GRIFFITH LETTER

Purpose

Documents contemporaneous treating psychiatrist observations regarding delirium and medical causation.

Key Findings

Dr. Griffith documents:

- delirium
- urinary tract infection
- psychiatric symptoms associated with medical condition
- improvement following treatment

Core Significance

The Griffith letter identifies a medical explanation for the presentation and materially differs from the later chronic psychiatric framing reflected in the diversion record.

Supporting Materials

- Dr. Griffith correspondence

- PHF treatment records
 - medication records
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EXHIBIT F — MEDICATION RECORDS

Purpose

Documents medication sequence and timing relative to identification of the urinary tract infection.

Medications Documented

- Zyprexa (olanzapine)
- Haldol (haloperidol)
- Ativan (lorazepam)
- Cogentin (benztropine)
- Seroquel (quetiapine)
- Antibiotics following UTI identification

Clinical Context

The records reflect:

- antipsychotic medications initiated before UTI identification
- involuntary medication proceedings
- later antibiotic treatment
- eventual stabilization

Seroquel Dosage Context

The outpatient dosage documented prior to hospitalization was 25 mg.

The records do not reflect a longstanding pattern of sustained high-dose antipsychotic treatment commonly associated with chronic psychotic illness.

Core Finding

The medication chronology supports an acute medical crisis framework rather than longstanding chronic psychotic deterioration.

EXHIBIT G — DUE PROCESS AND SEQUENCE FAILURE

Purpose

Documents reversal of the ordinary sequence of medical evaluation, capacity assessment, and charging.

Expected Sequence

1. Medical evaluation
2. Rule out underlying medical causes
3. Capacity assessment
4. Treatment of medical condition
5. Charging decision if appropriate

Actual Sequence Reflected in the Records

1. Emergency response
2. Jail custody
3. Charges filed
4. Psychiatric medications initiated
5. Medical condition identified later
6. Antibiotics initiated
7. Symptoms resolve

Core Concern

The records raise substantial questions regarding whether the criminal framework was established before the underlying medical condition was properly identified.

Supporting Demonstratives

- Due Process Breakdown visual timeline
 - Due Process Sequence Failure graphic
 - Court timeline demonstrative
 - Medication timing graphic
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EXHIBIT H — FORENSIC RECORD DISCREPANCY ANALYSIS

Purpose

Compares the original 1997 Plesons consultation note with later diversion-related characterizations.

Core Discrepancies Identified

Provider Credential

Original record:

- Dennis J. Plesons, M.D.

Later characterization:

- Dennis Plesons, M.S.

Diagnosis

Original record:

- Dissociative Disorder with secondary depressive features
- no psychosis documented

Later characterization:

- schizoaffective disorder framework

Medication History

Original record:

- patient reluctant to take psychotropic medications

Later characterization:

- later medication history attributed to 1997 period

Omitted Findings

Original record documents:

- orientation intact
- memory intact
- no psychosis

- no homicidal/suicidal ideation

Core Finding

The later psychiatric framework materially differs from the original contemporaneous psychiatric evaluation.

EXHIBIT I — CURRENT CLINICAL CONTEXT

Purpose

Documents current treating psychiatrist framework and longitudinal review.

Current Clinical Framework

Current treatment reflects:

- PTSD/C-PTSD
- trauma-related symptoms
- dissociation/depersonalization
- review of possible prior diagnostic misinterpretation

Longitudinal Context

The current framework materially differs from the chronic psychotic framework later reflected in the diversion order.

Core Finding

The current treatment framework supports reevaluation of the diagnostic assumptions incorporated into the record.

EXHIBIT J — ONE-SIDED RECORD STRUCTURE

Purpose

Documents structural imbalance within the evidentiary record.

Documentary Pattern

The records substantially rely upon:

- reporting-party statements
- police narratives
- records created while the patient was incapacitated
- third-party descriptions of events

Missing or Limited Components

- meaningful patient participation
- balanced evidentiary review
- documented contemporaneous patient account
- complete medical-first assessment

Core Finding

The resulting record structure raises concerns regarding reliability and completeness.

EXHIBIT K — EQUITABLE TOLLING TIMELINE

Purpose

Explains delay between original proceedings and current correction request.

2019–2025

The relevant records and documentary inconsistencies were not fully available or understood.

Factors included:

- medical incapacity and trauma
- lack of access to records
- incomplete forensic review
- delayed recognition of documentary inconsistencies

2026

The request followed:

- acquisition of records
- forensic comparison review
- psychiatric reevaluation
- integrated chronology analysis

Core Finding

The delay was associated with incapacity, incomplete access to records, and later discovery of documentary discrepancies rather than intentional delay or neglect.

CONCLUSION

The current record reflects a criminal and psychiatric framework.

The documentary evidence reflects:

- a medical event,
- occurring during a period of documented incapacity,
- with delayed identification of the underlying infection,
- and subsequent improvement following medical treatment.

The request is that the official record accurately reflect the documented medical reality of the October 2019 event.